301. F.5.c.20. - Should the contractor submit the plan by the sixtieth day preceding the start of each option period following the start of health care delivery?

RESPONSE: Yes

302. F.5.c.3. - Does the contractor have to submit a plan by 120 days before health care delivery, or does the contractor have to have a fully working system with all connections tested?

RESPONSE: The contractor must be able to fulfill the Benchmark Test requirements of the TRICARE Operations Manual.

303. F.5.c.5. - Will the MTF's have specific performance requirements that the contractor needs to understand and plan for that are not included in either this solicitation or the TRICARE Operations Manual?

RESPONSE: No, the agreement will outline how the contractor will achieve the Objectives and Requirements of the Contract in relation to every MTF.

304. F.5.c.8. - Are these applications for the contractor to distribute to beneficiaries or is the contractor to deliver the applications to the Government? If the latter, where and in what quantity?

RESPONSE: These applications are for use by the beneficiaries.

305. F.5.c.9. - What information should the reports contain and to whom should the contractor send them?

RESPONSE: Please see the TRICARE Operations Manual, Chapter 15, Section 3, Paragraph 5 for the report content and recipients.

306. F.5.d.7. - Please confirm that the updates begin 120 calendar days before the start of health care delivery.

RESPONSE: Yes, please see the TRICARE Operations Manual, Chapter 1, Section 8, Paragraph 4.3.4.

307. G.3.a.(1)(b)[3] - Under what circumstances will a Military Treatment Facility pay a contractor directly, or does this apply to payments through DFAS for MTF reimbursement of MCS claims payments for MTF enrollees?

RESPONSE: ***revised 20 September 2002***

See G-3.b. This will be covered in an amendment.

308. G.3.a.(3)(m) - In this section and others, the Government assumes that TED processing is operational. When will the Government begin to use TEDs? What happens if it is not operational when this contract begins? Will the Government provide an on-site demonstration of the TED for all potential offerors?

RESPONSE: The Government will begin using TEDs for the Benchmark test. We will implement TEDs with the start of health care delivery. The system will be operational. We will not provide a demonstration.

309. G.3.a.(3)(q) - Will the Government collect the guarantee monies from any type of payment, including for example payment for accepted TEDs?

RESPONSE: Performance Guarantees due to the Government may be collected from any type of payment disbursed from TMA, including payment for accepted TEDS.

310. G.5. - Please provide the monthly "STAT II Report" for the past 12 months for all regions.

RESPONSE: This report is not available from TMA for the last 12 months. What specific information are you trying to obtain?

311. G.5. - Please explain what the monthly "STAT II Report" is and describe the data it contains.

RESPONSE: The STAT II report is an Eligibility report produced by DMDC using DEERS data.

312. H.1.a.(1) - Will the outpatient and mail order pharmacy services include the pharmacy services delivered by providers in the home and a provider offices? Will medications delivered Point of Sale in non-network retail pharmacy remain under the managed care support.

RESPONSE: Pharmaceuticals delivered by providers in the home or office and billed by the provider (not the pharmacy) are the responsibility of the Managed Care Support Contractor. Medications delivered at a retail pharmacy are the responsibility of the pharmacy contractor.

313. H.1.b.(2) - Does the profit restriction apply to both the administrative and health care component of Change Orders?

RESPONSE: Profit rates are set at time of award for health care costs only. See answer to question 400.

314. H.1.b.(2) - Section B does not allow for an Underwriting fee percentage. How will the OP 2 - 5 underwriting fees be determined without a proposed % in section B. Section B only allows for a total dollar figure to be proposed. Please explain how the amounts proposed in the fee CLIN's will be adjusted for the effect of medical cost growth. Should the contractor bid fee amounts that are based on OP 1 health cost levels with an understanding that these amounts will be adjusted upward for health cost growth, or should the contractor propose increasing fees each year in an attempt to try to estimate the expected level of health cost growth in OP 2 - 5?

RESPONSE: Section B of the RFP will be revised to allow for the Underwriting Fee percentage to be input in the Supplies/Services column under the line item description.
(e.g., 0308AB Underwriting Fee (Fee percentage - _____).

Fixed underwriting fees proposed for Option Period II – V will not be adjusted for changes in health care cost levels. Offerors should consider whatever information they deem necessary to determine their proposed fixed underwriting fees for Option Periods II through V.

315. H.1.b.(2)(b) - In the event of a non-negotiated Option Period 2 health care target cost, how will the Government determine the cost (since the Option Period 1 target cost is for a partial year, depending on the timing of regional transitions)?

RESPONSE: If the retroactive formula is needed to set the Option Period II target cost, due to unsuccessful negotiations, for the prior year's actual healthcare cost in the region, the prior year's data would include some months covered by the prior managed care contract and some months covered by the newly awarded contract. Similarly, for the national trend factor term in the formula, the prior year actual costs would reflect 12 months of national data, but some of the months in some regions would reflect healthcare cost data from the previous managed care contract rather than the newly awarded contract.

316. H.1.b.(2)(c) - Will the Government make regional adjustments to the national trend factor to accommodate regional differences in healthcare costs?

RESPONSE: No. While the first part of the formula (the actual costs in the previous year in that region) accounts for regional differences in the level of health care costs, the national trend percentage will not be adjusted for regional differences.

317. H.1.b.(2)(c) - Please define the national trend factor and explain how and from what data sources the Government will calculate it.

RESPONSE: See the response to question 76.

318. H.10. - Please clarify what the Government means by the sentence, "In instances of multiple siblings, the hierarchy shall default fall to youngest to oldest sibling."

RESPONSE: In determining the financial assignment of the newborn during the 120 deemed Prime enrollment period if the mother is not enrolled in the region or is Active Duty one should check to see if there are any siblings enrolled in the region, if there are and more than one sibling is enrolled in the region than the youngest sibling's enrollment status should be used for assignment of the newborn. If the youngest child is not enrolled but there are other siblings enrolled in the region the default for assignment of the newborn is to the youngest sibling enrolled in the region. If there are not any siblings enrolled in the region than continue with the algorithm flow as outlined.

319. H.11.a.(2)(b) - The provision states in two locations that absent any of the required documentation, the payment error will be removed. Should the provision state that absent the documentation, the payment error will NOT be removed?

RESPONSE: ***revised 13 September 2002***

Section H.11.a.(2)(b) will be removed in a future amendment.

320. H.8.b. - In the event the Government changes the standards by unilateral contract modification or by statute, will the Government renegotiate the performance guarantee requirements? (It is understood that the Government will not change the amount of the performance guarantee.) If the Government's action or inaction

causes in whole or in part the contractor's failure to meet the standard will the Government exempt the contractor in whole or in part from the withhold that would be attributable to the failure?

RESPONSE: Unknown legislation or other changes cannot be addressed at this time. The Contracting Officer does have the authority to relieve the contractor. This will be managed on a case-by-case basis.

321. H.8.e. - The requirement appears to discourage research during a call to answer any but the most basic beneficiary inquiries. For example, a contractor phone representative would be unable to print and retrieve documents sent by the caller to discuss during the initial
phone call under this requirement. The requirement seems to provide a negative incentive to complete inquiries on the first contact. Did the Government determine that this was an industry best practice?

RESPONSE: This does not, in any way, discourage comprehensive responses during the initial call. It does require contractors to maintain a dialogue with the caller rather than placing the caller on hold for unacceptable periods of time.

322. I.109.(a) - The Government has not specified the minimum liability insurance amount. Please advise whether the offeror should propose an amount or whether the Government will mandate an amount.

RESPONSE: The fill-in data for this clause will be provided in a future amendment.

323. I.109.(b) - Does the Contracting Officer plan to request this evidence prior to or after submission of the technical proposal and financial information?

RESPONSE: The clause states the apparently successful offeror shall furnish evidence of its insurability upon request by the Contracting Officer. It has not yet been determined when this evidence will be requested.

324. J-2.12. - The North Region contains five of the seven US Family Health Plan Designated Providers. Which one of the five's address and phone number should the North contractor list in item 12?

RESPONSE: All five.

325. J-2.III. - Can the Government alter the form to collect information on whether the beneficiary's other health insurance covers prescription drugs? Can the Government alter the form to collect information on exactly which family members have other health insurance?

RESPONSE: For the purposes of this solicitation offerors must bid on the form, as written. We will, however, consider your suggestions.

326. J-2. VI.3. - May the contractor propose to accept other credit cards besides VISA and Master Card? If so, will the Government alter the form to so state?

RESPONSE: Yes, offerors may propose accepting additional cards. The Government will consider, but will not commit to modifying the form to comply with a contractor's proposal.

327. J-3.10. - The North Region contains five of the seven US Family Health Plan Designated Providers. Which of one of the five's phone number should the North contractor list?

RESPONSE: All five

328. J-3.8. - The North Region contains five of the seven US Family Health Plan Designated Providers. Which of one of the five's address should the North contractor list?

RESPONSE: All five

329. J-3.II.1.d. Section II. 1.d., 2.d., and 3.d. "Loss of Prime eligibility due to turning 65 years of age" is listed as a disenrollment reason, but the form qualifies this reason as for Prime only. Only non-active duty family member Managed Care Support contractor Prime enrollees lose Prime eligibility due to turning 65 years of age. Is it the Government's intent to distinguish between TRICARE Prime enrollment with a managed care support services contractor and TRICARE Prime enrollment with a US Family Health Plan?

RESPONSE: Yes

330. L.10.h. - In past procurements, the Government has set the final due date to be at least 30 days following the close of discussions. Is this the Government's intent in this bid?

RESPONSE: No, the reference clearly states the Government intends to award without discussions.

331. L.11.c. - Reference the January 5, 1999 memorandum on anticompetitive teaming issued by the Under Secretary of Defense (Acquisition): It is our understanding that one of the two current TRICARE fiscal intermediary subcontractors has signed an exclusive national contract with one of the current Managed Care Support contractors. Given this development, in the context of the referenced memorandum, is this exclusive arrangement in fact in the best interest of the program, or is perhaps a regional exclusivity agreement less restrictive and more advantageous to the program?

RESPONSE: Without documented evidence, we have no position on this allegation. However, it does not appear from the information presented in the question that the referenced memorandum is applicable. This is because the referenced memorandum is focused on situations where competition would cease to exist. As noted in the question, there are currently two TRICARE claims processors which seem to make the focus of the memorandum irrelevant to the current situation. Further, we have deliberately structured the Government's requirements in a manner that will allow and encourage companies with claims processing expertise to actively compete in this procurement.

332. L.12. - Should an offeror submit the Standard Form 33 and the Section K Representations and Certifications in electronic format? If so, on which CD specified in L.10.f.? If not, considering that offerors submit different parts of the proposal on different dates (e.g., past performance document 30 days before submission of

technical proposal), with which proposal document should the offeror submit the Standard Form 33 and the Section K Representations and Certifications?

RESPONSE: Standard Form 33 and Section K are to be submitted in paper copy as well as electronic format. Insure the Standard Form 33 has an original signature.

333. L.12.c. - In L-10.f., the Government has specified that offerors should submit two sets of separate CDs for the (1) technical proposal (written and oral), (2) past performance, (3) financial, (4) cost, (5) subcontracting. Please clarify the term, "separate entities," and how it might differ from the above-referenced CD submission instructions.

RESPONSE: The two references are the same. The oral presentation slides referenced in L-12 are part of the technical proposal referenced in both sections.

334. L.12.d.(10) - May outside consultants be present at the oral presentation, even though they are not permitted to conduct the presentation? May outside consultants be present during the two hour period designated for preparing answers to the Government's questions?

RESPONSE: Offerors may invite outside consultants; however, they may not participate in the oral presentation in any manner.

335. L.12.d.(11) - The schedule for the first day indicates the offeror's presentation runs from 8:00 a.m. – 12:45 a.m. Please confirm that the correct duration of the offeror's presentation is from 8:00 a.m. – 12:45 p.m.

RESPONSE: You are correct. The presentations will end at 12:45 p.m. Amendment 0001 corrected this.

336. L.12.d.(3) - May the offeror present any written material contained in any of the submitted proposal CDs, or is the offeror limited to only the written material contained in the technical proposal CD? Finally, is the offeror limited to just the written material that represents printed versions of the oral presentation slides? May the offeror supplement the information on the oral presentation slides?

RESPONSE: The oral presentations are limited to material contained in the technical proposal CD. Please refer to Section L-12 for the answer to the remainder of your question.

337. L.12.d.(9) - Does the offeror have to remain at the oral presentation location during the two hour period designated for preparing answers to the Government's questions? Does the offeror have to present its answers orally, in writing, or both? If in writing, in what format (e.g. Word, PowerPoint, or other) and will the Government provide a printer to produce the written answers? If there will be a printer, will it have the capability to print in color?

RESPONSE: No, the offeror does not have to remain at the oral presentation location during the two hour period designated for preparing answers to the Government's questions. However, the offeror must include travel time in their planning as no extensions to the two hour period will be considered. Answers are to be presented orally, only.

338. L.12.e.(1)(a)[2] - Not all TRICARE Plus enrollees are eligible for CHAMPUS and thus for network specialty services. Does the contractor need to size its specialty network for TRICARE Plus enrollees who are eligible for care only in the direct care system?

RESPONSE: Yes, the contractor is being hired to bring a high level of service to all MHS beneficiaries.

339. L.12.e.(2)(f) - Is the Managed Care Support Contractor responsible for providing claims customer service for the Medicare population, that is, for explaining how the TRICARE Dual Eligible Fiscal Intermediary contractor processed claims? Must the Managed Care Support Contractor perform marketing and education for the TRICARE/Medicare dual eligible population? Must the Managed Care Support Contractor provide referral management, care management, case management, or other medical management services to the (1) TRICARE/Medicare dual eligible population under age 65 and (2) the TRICARE/Medicare dual eligible population over age 65?

RESPONSE: Yes, the MCSC is responsible for providing general claims customer service for the Medicare population. This includes, but is not limited to, assisting a beneficiary read an EOB, explaining general reimbursement methodologies, responding to general coverage questions, and providing claims submission information/instructions/forms. Specific claims questions that cannot be answered based on general information or an EOB must be referred to the TDEFI contractor. Examples of this include status of a claim, duplicate payments, and alleged errors in processing. Yes, the Managed Care Support Contractor must perform marketing and education for the TRICARE/Medicare dual eligible population. Yes, the Managed Care Support Contractor must provide referral management services to the dual eligible population regardless of age. The Managed Care Support Contractor need not provide care management, case management, or other medical management services to the dual eligible population as long as TRICARE is secondary payor.

340. L.12.f.(1)(a) - Is there a limit to the number of oral presentation slides? Is there a limit to the number of pages in the written technical proposal?

RESPONSE: There is no limit on the number of oral presentation slides; however, any slide not individually addressed, discussed or presented during the oral presentation will not be evaluated. There is no page limit on written technical proposals. This is a content limit. Offerors are cautioned to carefully monitor the content, as the Government will consider proposal preparation as a reflection of the offeror's abilities.

341. L.12.f.(2)(a) - Please confirm that the Past Performance Information is due not later than 14:00 hours (MT), October 2, 2002.

RESPONSE: Confirmed

342. L.12.f.(2)(b) - What exact time period does the Government mean by "within the last three years"? Is it three calendar years 2000, 2001, and 2002? Is it exactly three years prior to the date of the issuance of the RFP?

RESPONSE: Please see Amendment 0001 clarifying the 3 year period.

343. L.12.f.(2)(d) - Given that an offeror's sole line of business could be TRICARE, for purposes of obtaining past performance reports could an "account" could include Resource Sharing or Resource Support agreements with individual Military Treatment Facilities?

RESPONSE: No

344. L.12.f.(2)(d) - Please confirm that the Past Performance Report (Attachment L-4) will be used for meeting this requirement.

RESPONSE: Confirmed

345. L.12.f.(2)(e) - Does the offeror need to submit three Government accounts if it has at least one Government account in its overall top five, or does the offeror need to submit three Government accounts if it has any number less than five Government accounts in its overall top five?

RESPONSE: The offeror must submit 3 Government Accounts. If these 3 are in the top 5, the offeror need submit no additional Government accounts. However, if 2 Government accounts are included in the top 5, the offeror must submit 1 additional Government account or state there is no additional Government accounts.

346. L.12.f.(2)(h) - Should an offeror use the Key Personnel Information sheet (Attachment L-6) for this requirement? If so, the form does not mention references. Please clarify if the Key Personnel Information is to include a list of personal references.

RESPONSE: Yes, please use the attachment. The reference is to forms and refers to all forms provided, not just Attachment L-6. No references are required on Attachment L-6 but may be provided.

347. L.12.f.(4)(d) - Is the requirement to include in the proposal the cost of evaluating new practices, devices, medicines, etc., or is it to include the health care cost of covering these new items? How can an offeror include in its proposal any valid estimate of the cost of new practices, devices, medicines, etc. that may evolve in future years?

RESPONSE: These are health care costs which can be projected based on current trends and historical precedent.

348. L.12.f.(4)(g) - This provision indicates that the Government will not initially require cost or pricing data. Nevertheless, the contract includes in Section I FAR clause 52.215-10, which only applies if the Government requires cost or pricing data as part of initial award. Could the Government delete the FAR clause in section I, and then it back if the Government later requires cost or pricing data?

RESPONSE: No, the Government will not consider deleting the clause from the RFP. However, the Government may consider removing when the contracts are awarded.

349. L.12.f.(4)(i)(3) - The per claim rate buildup specifies that overhead not associated with adjudication should not be included. The CAS provisions that Section I incorporates require that the contractor must fully allocate General and Administrative costs to all direct costs based on the established accounting practices

of the contractor. These provisions apply to cost estimating/proposal, actual accounting for costs, and billed or claimed costs. Does the Government intend for offerors to bid General and Administrative costs associated with the claims processing direct costs as part of the claims processing CLIN? If not, please explain the method of proposing the claims processing General and Administrative cost as part of the proposed price under the contract consistent with the requirements of the CAS.

RESPONSE: Yes. The price should be inclusive of all costs (e.g., direct, indirect costs, general & administrative, facilities capital cost of money, etc.) applicable to claims adjudication.

350. L.12.f.(4)(i)(4) - The TRICARE Service Center CLIN requires the offeror to include in the price only the cost of staff, equipment, and service required to accomplish the function. The CAS provisions that Section I incorporates require that the contractor must fully allocate General and Administrative costs to all direct costs based on the established accounting practices of the contractor. These provisions apply to cost estimating/proposal, actual accounting for costs, and billed or claimed costs. Does the solicitation require that:

a. all G&A and overhead related to TRICARE Service Centers should be bid on the TSC CLIN?
b. all G&A and overhead costs should be allocated and proposed in accordance with Cost Accounting Standards, but included in the CLIN for the PMPM amount?
c. the Contracting Officer will have to pursue a CAS waiver under this contract?

RESPONSE: Offerors should propose a fully-burdened price for the operation of the TRICARE Service Centers line items consistent with the offeror's disclosed accounting practices along with the applicable profit to calculate the total price. This would include any indirect costs, general & administrative costs, facilities capital cost of money, etc.

351. L.12.f.(4)(i)(6) - Does the transition out expense include costs of severance, or will the Government continue to handle this on a case by case basis?

RESPONSE: Offerors shall determine the costs that will be included in their proposed transition-out prices. Severance costs are allowable IAW FAR Part 31 and will not be handled separately.

352. L.13.a. - Should an offeror include the performance guarantee and award fee proposals in the cost proposal or the technical proposal? If the latter, should the offeror include them in the oral presentation slides or in the written technical proposal?

RESPONSE: Performance guarantee amounts should be proposed in Sub-Section H-8. The corresponding award fee pool amounts should be included in Section B, which is to be submitted as part of the cost proposal. No information is required to be submitted as part of the technical proposal.

353. Reference Section C-7.1.16 of the RFP - for purposes of the one-hour reporting requirement, will the Government please specify what is meant by urgent/emergent preliminary report of a specialty consultation.

RESPONSE: Please see the definition of urgent care in the TRICARE Operations Manual and the definition of Emergent care in the TRICARE Policy Manual.

354. Reference Section C-7.1.16 of the RFP - does the Government expect a HIPAA compliant electronic interface to be developed between the civilian provider network (facilities as well as individual providers) and the MTF for the exchange of information?

RESPONSE: The Government expects the prime contractor to propose their best practice for ensuring the results are received timely.

355. Under the provisions of the MCS solicitation, may contractors and/or subcontractors offer to market non-TRICARE products and services to MHS beneficiaries that are offered to the contractor's commercial customers/members?

RESPONSE: No

356. Is the Service Contract Act (SCA) a requirement for this contract?

RESPONSE: No

357. Our experience indicates that TFL beneficiaries nationwide will call customer service or visit Tics almost 250,000 times annually seeking assistance. The RFP indicates that contractors will continue to serve these dual eligible MEDICARE beneficiaries. Since claim processing will be carved out of the TRICARE contracts, what access will the contractors have to the new third party claims processor's proprietary management information system to respond to those inquiries?

RESPONSE: None. When this level of information is required, the beneficiary must be referred to the appropriate contractor. The MCSC must, however, continue to provide all beneficiaries with the highest level of customer service possible. This includes, for instance, assistance reading an EOB, claims filing assistance, program benefit and reimbursement information, referrals, enrollment, and all other assistance than can be provided.

358. When the retail pharmacy contract is awarded, beneficiaries must be made to understand that their MCSC customer service lines will not be able to help them with their pharmacy issues and they must be re-directed to the Retail Pharmacy Contractor. Satisfaction with the health plan is a reflection of all components of that plan. How does the government intend to account for the performance of the Retail Pharmacy vendor as it impacts beneficiary satisfaction?

RESPONSE: The first statement is not entirely true. MCSCs must assist any MHS beneficiary in understanding their total TRICARE benefit. Only those issues that the Retail Pharmacy contractor has taken action on (claim status, appeals status, etc.) should the MCSC helpfully refer the beneficiary. The beneficiary satisfaction survey specially asks the beneficiary to consider the following areas of the MCSCs not any other contractor. The measurement of the performance of the Retail Pharmacy contractor is under develop and will be part of that future contract.

359. Reference Section C-7.1.16 of the RFP - please clarify if the delivery of 98% of the specialty network consultations is required only to MTF PCMs or to all PCMs, including civilian?

RESPONSE: No, this requirement is based on clinical need for information, not the location of the PCM.

360. To determine if a significant change in requirements has occurred, please identify the new Manual references for the following Chapters of the MCSC Operations Manual 6010.49 issued March 2001, which are not included as Chapters in the TRICARE Operations Manual 6010.51-M issued August 1, 2002, which is to be used with this solicitation:

[a] Chapter 17 - Program for Persons With Disabilities (PFPWD)
[b] Chapter 18 - CHAMPUS/VA Agreement
[c] Specialized Treatment Services.

RESPONSE: (a) PFPWD. All information on PFPWD is contained in the TRICARE Policy Manual, Chapter 9, and was removed from the Operations Manual.

(b)The policy on Department of Veteran Affairs and Department of Defense Health Care Resource Sharing has been removed from the Operations Manual and placed in the TRICARE Policy Manual, Chapter 1, Section 12.1

(c) The Specialized Treatment Services (STS) Program is ending and will not be included in the new contracts so all references to STS have been removed from all the manuals.

361. Reference Section C-7.1.10 of the RFP - please identify the documentation required and the mechanism to be used, if required, to obtain provider specific exceptions to the 100% EMC requirement for network providers.

RESPONSE: The documentation will depend on the situation. For example, a subspecialty is needed in Minot, SD and the only physician available refuses to participate solely on the basis of the EMC requirement. The contractor would have to document the specific attempts to attract the physician to the network; e.g., meetings to outline the benefits of EMC for the physician, offerings to provide a computer and training, etc. The mechanism is a fully documented written request to the Regional Administrative Contracting Officer who will consult with the Regional Director.

362. Reference RFP Section C-7.1.10 - At the claims processing improvements meetings in May, 2002, TMA presented industry comparison data that showed that the national average for EMC submissions for all health plans was 40%, and that data appears to have included pharmacy. There are number of reasons why EMC submission is so low, specifically in relation to TRICARE. As with most other health plans, TRICARE has unique requirements for data elements like provider identifiers, sponsor/patient identifiers, etc. Providers will not modify their practice management systems for small volume customers. The current HIPAA regulations will not solve all of these differences. Many practice management systems can not file claims electronically to secondary payers. TRICARE is secondary to everything except Medicaid. Many types of claims require hardcopy supporting documentation. Most providers will send these claims on paper so they can physically attach the documentation. Finally, providers who have not taken the necessary steps to comply with HIPAA will not legally be allowed to file claims electronically to insurers after 10/16/03. They will have to drop all of their claims to paper. Given these circumstances, will the government consider changing the 100% EMC submission

requirements for network providers and instead benchmark current EMC rates and establish reasonable performance expectations for maintaining or improving that performance?

RESPONSE: Your assertions have valid points. However, we feel that with the proper incentives and with the growing providers' realization that for the future it is in their best interest to "get on the EMC bandwagon" to assist in accurate claims submission and prompt payments, that this requirement is reasonable. In those few cases of a specialty need, then we have allowed an exception process.

363. Reference Sections C-7.1.16 and H-8.m. - While it is recognized that prompt communication with the primary care provider is important, there would be great difficulty in complying with the timeliness standards for routine and urgent/emergency specialty referral reports mandated in the RFP for the following reasons:
the process for tracking and measuring this standard does not exist and to implement it will be costly;
the referral process and the consultant's written response involves several sub-processes which are not controlled by the MCO/contractor, e.g. the process the physician uses to communicate their findings, such as handwritten notes, dictation system, e-mail;
the managed care industry does not use this standard in their contracts because of a lack of systems to measure or track it. Hospitals have a requirement for timeliness of hospital medical care delivered in their facilities. Managed care organizations are not health care delivery systems and do not have this type of control over the network physicians;
neither URAC nor NCQA have a standard related to measuring the requirements in this standard;
the legibility requirement is very important, but we would have no way to measure this for all of the written records delivered to the PCMs; and
the process for meeting this standard encompasses having a managed care organization (MCO) involved at the micro-management level of providers' office processes.
Will the government consider changing this requirement to a goal of 10 days for routine consultation with contractors committing best efforts to improving responsiveness of network providers without assigning penalties or the need for corrective action plans?

RESPONSE: ***revised 20 September 2002***

RESPONSE: We agree with your assertions and have listened to industry. In a future amendment we will extend the time frame from 5 working days to 10 workings for the submission of a routine referral report. This solicitation has no penalties but does have performance guarantees. The Government is not considering deleting the performance guarantee of Section H-8.m. nor will it eliminate the need for corrective action plans when there is a failure of more than 2% of the sampled referral reports to meet the standard. A well managed health plan ensures that the information required to treat a patient is readily and rapidly available to the treating clinician.

364. Section J, Attachment 2 of the RFP, states annual and quarterly renewal invoices will be sent, but not monthly invoices. The payment options for enrollment fees include the ability to auto charge annual and quarterly payments to beneficiary

credit cards. If auto charged, the need to send renewal invoices seems to no longer exist. Please clarify as to whether or not annual or quarterly bills need to be sent if the beneficiary has elected to auto charge his or her credit card.

RESPONSE: Yes, the notices are required. However, a beneficiary may choose to waive his or her right to receive an annual or quarterly bill since they will be receiving that information on the credit card monthly billing. In that case, the contractor must document that decision in a manner of its own choosing and cease sending the bills.

365. Section J, Attachment 2 of the RFP offers the beneficiary the opportunity to pay enrollment fees through use of a payroll allotment. Please indicate where procedures are written for the contractor to interface with the payment offices of the services to receive transmissions and EFT payments for payroll allotments. Also, how are changes in status (e.g. starts and stops) of deductions to be communicated between the contractor, beneficiary and the payment office in order to correctly administer the payroll deductions?

RESPONSE: Enrollment fees may be paid through a payroll allotment. For example, the retiree will initiate an allotment through a payroll office of their choosing. This information will be entered into one of the Defense Finance and Accounting Systems (DFAS). DFAS will process and pay the contractor through the use of the ANSIX12N 820. The contractor will record the payment according to the requirements of the TSM, Chapter 3. During the transitions specifications meeting, the contractor and DFAS will exchange electronic addresses and other relevant information necessary to complete these transactions. Changes in status will be received through NED (TSM, Chapter 3). Essentially, the beneficiary initiates the action, DFAS processes the allotment and monthly sends a payment to the contractor along with the identifiable beneficiary information, and the contractor accepts the payment and records it appropriately.

366. Attachment L-3, 7.1 of the RFP states the award fee is based on three components. Are the three components weighted equally? If not, could the government provide the proper weights?

RESPONSE: The award fee determination is a subjective judgement, not a mathematical formula, by the senior executive of each of our regions designed to incentivize the contractor to achieve the highest level of customer satisfaction. The customers of the TRICARE Management Activity and the managed care support contractors are the beneficiaries, MTF Commanders, and Regional Directors. The award fee will be based on the MCSC's ability to satisfy these customers.

367. Attachment L-3, 7.2 of the RFP indicates the AFDO issues the award fee determination and he/she must include the rationale for their decision. This implies there is subjectivity in determining fees. If the awards are based on the quantifiable results of surveys, why is any rationale needed for justification? Could the government describe any situations in which a fee would be earned based on the survey results, but a fee not being awarded or reduced by the AFDO?

RESPONSE: The award fee is purely subjective.

368. Section C-7.21.2 of the RFP states that "the contractor shall provide data at the beneficiary, non-institutional and institutional level with the intent of providing

the Government with access to the contractor's full set of data associated with TRICARE. The data shall include, but is not limited to, data concerning the provider network, enrollment information, referrals, authorizations, claims processing, program administration, beneficiary satisfaction and services, and incurred cost data." By "claims processing and incurred cost data" do you mean TEDS? If not, please explain what is desired. By the "provider network", do you mean HCPR? If not, please explain what is desired.

RESPONSE: By incurred costs, we are referring to the cost of health care. By provider network we are referring to all materials contained in the contractor's data warehouse related to the network. We have not specified the full extent of data required. Rather, we have asked offerors to provide the Government with access to the information they maintain in their data warehouse employing their "best practices."

369. Reference RFP Sections C-7.1.16 and C-7.2 - in so far as the requirements for provision of referral reports to the PCM, the contractor has no control of possible delays in MTF mail room processes, or routing of faxes and reports within the MTF. Will the government accept transmission of the consultation report by fax or secure email to an MTF designated fax number or email address as meeting the requirement to provide reports to the PCM?

RESPONSE: The Government has no expectation that the MCSC will accomplish internal distribution for our MTFs. The contractor is simply required to ensure that the reports are delivered to the providers location timely. While you have introduced several possible acceptable methods, the MTF distribution point is a matter to be included in the MOU between the contractor and the MTF Commander. A single point at each MTF will fulfill the RFP requirement.

370. Sections C-7.1.16 and H-8.m. require the contractor to ensure that network specialty providers provide clearly legible specialty care consultation or referral reports, operative reports, and discharge summaries to the beneficiary's primary care manager within five working days of the specialty encounter 98% of the time. Paragraph H-8.m. contains a similar requirement. Is the Government committing to the same standard when a referral is made from a civilian PCM to an MTF specialist?

RESPONSE: ***revised 20 September 2002***

RESPONSE: The purpose of this RFP is to establish the services the Government wishes to purchase. The government is not committing to the same standard as required by the contractor. However, this will be dealt with in a future amendment to change to the 5 working day requirement.

371. Section C-7.3.3 of the RFP requires that the contractor achieve the 50th percentile or above on all measurements contained in HEDIS for Prime enrollees with network PCMs. The following questions pertain to this requirement:

a. NCQA allows a health plan to not report some measures if the plan performed well on those measures in prior reporting periods. Will TMA follow NCQA practice in this regard?

RESPONSE *REVISED 30 December 2002*

RESPONSE: No. The requirement to performance the HEDIS standards was deleted in an amendment and replaced with Government monitored quality assurance standards. Contractor will need to perform on all performance measures on the Government's list each year.

b. NCQA requires accredited health plans to have their HEDIS reports undergo external validation (audit) by an NCQA certified vendor. This validation costs large accredited plans hundreds of thousands of dollars annually. Does the government require external validation of HEDIS reports?

RESPONSE *REVISED 30 December 2002*

RESPONSE: The government will not require external validation of the quality assurance measures identified by the Government.

c. Does the government intend for contractor's to use the 2002 or 2003 HEDIS standards? In the commercial world, insurers can rotate indicators for reporting. Which indicators does the government require that we use?

RESPONSE *REVISED 30 December 2002*

RESPONSE: See above.

d. HEDIS 2003 consists of 52 measures across 8 domains of care. Management information relating to six domains (Access/Availability of Care, Satisfaction with the Experience of Care, Health Plan Stability, Use of Services, Cost of Care, and Health Plan Descriptive Information) will be available to the government through other requirements and provisions of this contract. Does the government desire HEDIS reporting in all domains? Will reporting of only those elements in the Effectiveness of Care domain satisfy the requirement of C-7.3.3?

RESPONSE *REVISED 30 December 2002*

RESPONSE: See above; the Government will select the measures, establish targets, and publish the results.

e. HEDIS Effectiveness of Care standards require two years of continuous enrollment prior to reporting. This would result in first reporting 30 months after the contract start date. Is this the intent of the C-7.3.3 requirement? If not, how will the contractor address HEDIS requirement of continuous enrollment?

RESPONSE *REVISED 30 December 2002*

RESPONSE: See above.

f. Certain HEDIS measures apply only to Medicaid or Medicare populations (for example, Medicare Health Outcomes Survey, CAHPS® 3.0H Adult Survey, CAHPS® 3.0H Child Survey) or Managed Behavioral Health Organizations (ECHO™ 1.0H Survey for MBHOs). Does the government desire HEDIS measures that are not usually reported for commercial populations? If so, please clarify scope of required measures.

RESPONSE *REVISED 30 December 2002*

RESPONSE: See above.

g. HEDIS prescribes a costly "hybrid" method to gather data for Effectiveness of Care Measures. This method requires review of medical records to capture care that is not recorded in administrative data. Please confirm the government desires to purchase collection of data by this method. Would the government accept reporting based on administrative data only?

RESPONSE *REVISED 30 December 2002*

RESPONSE: See above. The Government's measures will be based on administrative data or surveys.

h. Many beneficiaries will use MTFs for certain services that must be tracked and reported. In our current contracts, MTFs have not been able to provide us with that information. How does the government intend for contractors to get the needed information?

RESPONSE *REVISED 30 December 2002*

RESPONSE: See above. The Government's published results will be based both on purchased and MTF data.

i. During what time frame does the Government expect the contractor to achieve the 50th percentile on these HEDIS measurements? The standard for contractors to achieve 50th percentile of all reporting plans in their first reporting period may be unrealistic. Would the government consider using the first HEDIS reporting period to establish baselines for the program, then improving performance levels in subsequent years?

RESPONSE *REVISED 30 December 2002*

RESPONSE: For the Government designated measures, the Government will provide the annual targets.

372. Section C.7.2 of the RFP requires the contractor to audit 2% or 10 MTF referrals (whichever is greater) on a monthly basis and to achieve a 98% compliance rate for a five day turnaround. Failure to meet the five day standard requires a corrective action plan. Will the MTF provide a copy of referrals and date of receipt or will the contractor have to establish a clearinghouse to maintain files of all reports and records of receipt?

RESPONSE: The contractor is responsible for tracking each referral from the MTF since the sample is based on referrals through the contractor.

373. Reference the five day turnaround time required in Section C.7.2 of the RFP - Will further education of the specialist be sufficient or will contractors be expected to establish a proactive monitoring process of scheduled appointments (and changes thereto) and prompt providers that referral reports are due? If this type of action is required, how will contractor get access to appointment information?

RESPONSE: All referrals will go through the contractor. Any access to appointment

information should be addressed in the MOUs with the MTFs.

374. Reference Section C.7.20.2 of the RFP - Can the government provide additional detail on the types of information/services that the contractor must provide on a 24 hour basis? For example, does it include: information on network providers? Approval of visits to providers without PCM approval? Referral to ambulance services nationwide? Nurse triage or advice? Demand management services?

RESPONSE: Please see the revision to this provision contained in Amendment 0001.

375. Reference Section C.7.21.18 of the RFP - Will the government provide experience detail (how much & how often) concerning beneficiary payments in excess of normal co-pays arising from referred care from non-network hospital based physicians and non-network care as a result of a medical emergency so that the bidders can assess the impact and incorporate this often unavoidable cost in their fee requirements?

RESPONSE: You can find this information in the data tapes.

376. Reference Section C-7.19 of the RFP - please provide a definition of working in DoD Medical Treatment Facilities. Does this include contractor personnel who only enter the MTF on occasion in an official capacity or is it limited to those who actually have a workplace in the MTF?

RESPONSE: ***revised 24 September 2002***

RESPONSE: This provision applies to individuals whose place of work is the MTF. Visitors to the MTF must follow the rules established by each Installation Commander and the MTF Commander.

377. Reference Section C-7.1.3, Attachment L-1, and Section M-6.b of the RFP - if the Government does not "grandfather in" existing Prime beneficiaries in non-Prime required areas, does this action not bias subsequent beneficiary satisfaction surveys against the new MCS Contractor?

RESPONSE: No. The beneficiary survey is designed to reflect a customer service activity as the beneficiary interacts with the contractor directly or through the provider. While beneficiaries may rail against the Government's decision, it is not designed to capture the public's disagreement with policy. The survey agency will be instructing the beneficiary to focus on a visit.

378. Section C-7.15 of the RFP requires the incoming contractor to enroll all Prime beneficiaries to their assigned PCM. If a beneficiary was enrolled to a civilian PCM with the prior contractor, will they need an exception from the MTF Commander as described in section C-7.12?

RESPONSE: ***revised 20 September 2002***

RESPONSE: In an upcoming amendment, Section C-7.15. will be changed to read, "If a beneficiary's civilian primary care manager remains in the TRICARE network, the beneficiary may retain their primary care manager. If the beneficiary must change primary care managers, all enrollments shall be to the MTF until MTF

capacity, as determined by the MTF Commander, is reached.

379. Reference Section C-7.1.3 of the RFP - from what point does the clock start ticking regarding access standards? From the time the PCM writes the referral? From the time the MTF releases the referral? From the time the beneficiary calls for an appointment?

RESPONSE: From the time the beneficiary requests an appointment.

380. Section C.7.3 of the RFP requires that the contractor's referral management process evaluate any proposed service to determine if the type of service is a TRICARE benefit and inform the beneficiary if the requested service is not a benefit. Is this determination binding on the contractor for payment? If so, is the contractor liable for the cost? What about referrals for services that are covered but are allowed only with certain frequencies (for example: routine mammograms, nutritional therapy, hearing screening, and vision benefits)?

RESPONSE: The contractor is liable for their actions. However, you are asked to note that it is the "type of service" the beneficiary will be receiving and not the medical necessity and appropriateness of the service.

381. In Section C.7.3.1 of the RFP, MTFs have right of first refusal for all referrals in a catchment area. Since the contractors award fee will be partially determined by member satisfaction with the referral process, will the government commit to a turnaround time for MTFs to accept or decline a referral that will not jeopardize this satisfaction?

RESPONSE: Acceptable times will be addressed in the MOUs with each MTF.

382. Section C.7.3.2 of the RFP requires 96% of referrals in Prime service areas be to the MTF or to network providers. Significant penalties exist for failing to achieve that standard. The ACO may grant an exception based upon fully justified written requests from the contractor. In many small communities where Prime will be required, not all specialists are represented or there is little competition that would encourage some specialists or hospital based physicians to join at low TMAC rates. Are these circumstances sufficient for waiver approval?

RESPONSE: First, there are no penalties; performance guarantees are not considered penalties. Rather, the Performance Guarantees are the contractors assurance that the services the Government purchases will be delivered, as required. Second, the contractor is expected to deliver the services required in this RFP using whatever means are required rather than relying on a waiver of the requirement. Offerors are encouraged to recognize that their ability to build and maintain a network that fulfills the requirements of the RFP is an evaluation factor. As to your examples; they could be valid if the contractor first demonstrated some considerable effort to entice these providers into the network; e.g., offering incentives to join, providing special electronic access, etc. (These are only examples and do not specifically express the wishes of the Government.)

383. Reference Section C-7.3.2 of the RFP - please clarify improved performance levels for this contract? What percentage of improvement does the Government expect to reach during a contract period?

RESPONSE: It is the responsibility of the offeror to propose, in a competitive environment, the improvements to which they commit.

384. Reference Section C-7.3.3 of the RFP - is it the government intent to have this contractor achieve NCQA certification?

RESPONSE: No

385. Reference Section C-7.28 of the RFP - mention is made of a TRICARE Regional Executive Director. In order to understand theis function, would the government provide the intended organizational structure?

RESPONSE: Yes, however, the final governance structure has not yet been determined. There will be three Regional Directors and the existing Lead Agents will continue to be a key part of the overall governance structure. The Regional Director will be primarily responsible for the contract oversight and execution. The Lead Agents will be responsible for supporting the business plan that provides for patient care services in their area of responsibility (AOR). The Lead Agent will be focused on utilization of the military direct care system but will continue to have a working relationship with the Contractor in regard to the purchased care for the MTF's in their AOR.

386. Section C-7.3.2 of the RFP indicates services rendered in network institutions by hospital-based providers shall be counted as referrals even though no formal referral was made to that individual. How is a "hospital-based provider" defined? Will this "referral" be identified by a claim from the hospital-based provider? If so, will a single claim count as one referral, regardless of the number of service lines or service dates on that claim?

RESPONSE: A hospital based provider is defined as any provider required in the delivery of a service for which the beneficiary was referred. For example, a beneficiary referred for surgery may receive services from the surgeon, assistant surgeon, anesthesiologist, pathologist, radiologist, and hospitalist. How a referral will be identified will be based on how the contractor accomplishes the referral function.

387. Reference Section C-7.3.2 of the RFP - please more fully define services by hospital-based providers that shall be counted as referrals even though no formal referral was made to that individual. For example, would a pathology professional service on a laboratory test be a referral? Would an anesthesiologist's administration of epidural analgesia during labor be counted as a referral? Would a radiologist's interpretation of an outpatient radiology study be a referral? Would a physician service for emergency department care be a referral? Would a surgical assistant service be a referral?

RESPONSE: Please see our previous response. Please also remember that the purpose of this requirement is to ensure our beneficiaries access to network providers in order to ensure quality of care and to avoid the unnecessary costs associated with non-network clinicians.

388. RFP Section C-7.7.1 requires the contractor to operate disease and case management programs for all eligible beneficiaries (in excess of 2 million people) for

which proven clinical management programs exist. However, in Section B, the government only projects cost of $2 - 3M per year for such programs. Experience in the civilian sector is that much greater investment is expected to achieve real results. Must the contractor only bid services and patient selection that does not exceed this government estimated costs?

RESPONSE: The RFP does not require specific programs to be proposed. Specific Program proposals will be submitted after contracts are awarded in accordance with C-7.7.1. For the purposes of proposing, offerors are required to use the Government estimated costs.

389. Section C.7.42 of the RFP requires the contractor to "provide pharmaceuticals to beneficiaries in situations where the pharmaceuticals are not obtained from a retail pharmacy and consistent with the coverage usually provided under an outpatient pharmacy benefit." Does the government mean "provide coverage" or "provide"? Does this definition mean drugs provided during a hospital stay, chemotherapy, etc?

RESPONSE: The requirement is to provide coverage. We do not want the MCSCs developing pharmacy networks. Rather, the MCSC will provide coverage (indemnify) TRICARE beneficiaries for the cost of medication excluded from the TRICARE Retail Pharmacy contract and the TRICARE mail-order contract. See also the answer to 411.

390. In Sections C-7.44 and H-12 of the RFP the government reserves the right to unilaterally assign a contract to an alternative contractor on an interim basis. The selected alternate contractor only has 60 days to begin health care delivery. Could the government provide clarity on the following issues: what is the government process for determining a contract needs to be assigned to an alternate contractor? What is the government selection criteria for determining which alternate contractor is chosen? The fact that a contract is being reassigned to another contractor is an indication that problems exist within the regions. Given this fact and a short transition period of only 60 days, the likelihood of the incoming interim contractor meeting the Performance Guarantee standards in Section H is remote. Will the incoming contractor be subject to the financial penalties incurred for not meeting Performance Guarantee standards? Will contract performance on the interim basis be evaluated as part of a Past Performance review for future procurements?

RESPONSE: These provisions have been deleted/revised in Amendment 0001.

391. Reference Section C-7.37 of the RFP - regarding read-only access to claims data. Please provide the number of personnel in the DoD Operations Center, and the number of HBAs and BCACs by Region who will require access, training and support.

RESPONSE: See Question 428.

392. Section C-7.37.1 of the RFP states that the contractor shall provide unlimited read-only off-site electronic access to all TRICARE related data maintained by the contractor. Minimum access is further defined, as two authorizations at the Regional Director's Office, two authorizations at Health Affairs, two authorizations at TMA-Washington, two authorizations at TMA-Aurora, and authorization for each on-site Government representative. Is it the expectation of the Government to run ad-hoc queries on contractor systems by means of off-site access from each of the

authorized agencies mentioned in reference C-7.37.1. Alternatively, is the Government requirement of "unlimited read-only, off-site electronic access to all TRICARE related data" satisfied by providing unlimited download capability from contractor systems to Government systems at each of the authorized agencies mentioned in reference C-7.37.1.

RESPONSE: The second suggestion is partially acceptable. The contractor must have read-only access to the data in the contractor's system and it is acceptable to provide also unlimited download capability from contractor systems to Government systems. Offerors may wish to keep in mind that the Government requires access to the data in order to accomplish health planning, budgeting, and program administration activities.

393. Reference RFP Section C-7.9 - Can the government provide additional information about the frequency, type and content of information that the contractor shall provide the Marketing and Education contractor in order to price the requirement? What happens if the MCS and MKEC contractor cannot agree?

RESPONSE: The frequency shall be established in the MOU. The MCSC is free to provide any suggestions for materials that will assist the MCSC in achieving the objectives of the contract. There will be no disagreements between the MCSC and the MKEC contractor as the Government will determine what materials are eventually produced.

394. Reference Section E.3 of the RFP - will the government provide bidders with a copy of the performance audit checklists to be used by on-site ACOs and indicate the frequency and length of these audits?

RESPONSE: No. The Government will audit as it deems necessary to ensure receipt of the services being purchased through this RFP.

395. Reference RFP Section F-5.a. - The report described appears very broad requiring contractors to review and report on any drugs, devices, medical treatments or medical procedures that they believe have moved from unproven to proven. Can the government provide additional clarification on the requirement? Since the government will not adjust target cost for these new costs, will the criteria for coverage include cost efficacy compared to other alternatives or will the contractor be required to cover if the new activity produces medical value?

RESPONSE: The requirement is all inclusive. The criteria may be found in 32 C.F.R. 199.2.

396. The RFP indicates the Government's intent to establish a presence at the Prime contractor location and each major subcontractor location. The prime contractor may have administrative offices located throughout the region. Is it the Government's intent to have a presence at every administrative location, or at only major administrative locations?

RESPONSE: The intent is to purchase the capability to establish a presence only at the primary location of the prime contractors and the primary location of the first tier subcontractors. See also answers to 208 and 209.

397. In Section G-3 (l) [1] of the RFP contractors are paid for underwritten health

care costs only after the associated TED records clear all edits. This results in a significant negative cash flow situation for contractors. Given this condition, could the government explain the rationale for only paying contractors 50% of the target underwriting fee as stated in H-2 a.?

RESPONSE: These are two separate issues. First, a contractor processing claims accurately and who accurately submits TED records will not have a negative cash flow. The fee the contractor actually earns cannot be determined until the actual health care costs for the period are determined. As such, the Government is prospectively paying the contractor a reasonable amount until such time as the final fee determination is accomplished.

398. If a company bids as Prime on two contracts but can only be awarded one, if the contractor is the highest scored bidder on both, will the contractor be able to choose its contract or will this be a government-only decision?

RESPONSE: No

399. Reference RFP Section G-5 - Will the government adjust the target cost for changes in MHS eligible beneficiaries to respond to large changes (such as Reserve call-up under Noble Eagle or Desert Storm)?

RESPONSE *Revised 5 December 2002*

RESPONSE: Once the target cost for a given option period is set through the negotiation process, the target for that option period is not adjusted for changes in eligibles. The recent actual eligibles experienced can also be considered when negotiating the next year's target cost. Finally, in the event the fall-back formula is triggered to set the target cost for a given option period retroactively (because negotiations did not succeed by the mandated deadline), then the national trend factor used in that formula would implicitly include the effect of the national trend in eligibles that year, although not a region-specific eligibles effect.

400. Reference RFP Section H-1.c.(2). The government requires the contractor to agree to the same profit percentage for change orders as proposed for the initial contract. This seems inconsistent with other government contracts that allow for higher profits based on risks and complexity. A contractor who desires to give the government a lower rate for a large volume of business could actually lose money on change orders if change orders cannot be definitized and paid quickly. Will the government consider eliminating this limitation? Is the limit consistent with the DFAR, which recognizes legitimate profit differentials based on specified factors?

RESPONSE: Section H.1.b.(3) of the RFP states that "The parties agree to utilize the same profit percentage proposed for the initial award in these negotiated adjustments". The negotiated adjustments pertain to "negotiated health care changes, definitized health care change orders, or other equitable adjustments". This requirement pertains to profit on health care costs only. The Government will not eliminate this requirement and considers the position allowable in accordance with the FAR. FAR 15.404-4(b)(6) states that if a modification calls for essentially the same type and mix of work and is of relatively small dollar value when compared to the total contract, the contracting officer may use the basic contract's profit or fee rate to negotiate the change or modification. Since individual changes will be small when compared to the total contract and will be of the same type as the whole

contract, the Government believes it is within the rules to maintain the basic rate for changes and other equitable adjustments. If a change or other adjustment does not fit within the description, it is likely not within scope and will be dealt with appropriately. The DFARS details the methodology to be used if a structured approach for developing profit objectives is utilized. This methodology will be used for determining profit objectives for administrative change orders, and health care changes which are out of scope.